

**Children's Medical Services Branch  
 Child Health and Disability Prevention (CHDP) Program  
 CHDP Data Activation, Modification, Deactivation Request**

This form is to be used by the local CHDP Program Deputy Director to request access to CHDP data through Business Objects for local CHDP Program staff. This request will result in the assignment of confidential user identification (ID) and password. The form is also to be used to request modification or deactivation of a user ID. Please fill in the appropriate checkboxes, complete the required information for all requests, and attach a signed Confidentiality Oath for each person you add to the list. Please allow two week from the claim submitted for processing new requests.

STAFF PERSON INFORMATION			
Select One	Name and Position	E-Mail Address and Phone Number	Confidentiality Oath
<input type="checkbox"/> Add <input type="checkbox"/> Modify <input type="checkbox"/> Delete			<input type="checkbox"/> Signed <input type="checkbox"/> Attached
<input type="checkbox"/> Add <input type="checkbox"/> Modify <input type="checkbox"/> Delete			<input type="checkbox"/> Signed <input type="checkbox"/> Attached
<input type="checkbox"/> Add <input type="checkbox"/> Modify <input type="checkbox"/> Delete			<input type="checkbox"/> Signed <input type="checkbox"/> Attached
<input type="checkbox"/> Add <input type="checkbox"/> Modify <input type="checkbox"/> Delete			<input type="checkbox"/> Signed <input type="checkbox"/> Attached
<input type="checkbox"/> Add <input type="checkbox"/> Modify <input type="checkbox"/> Delete			<input type="checkbox"/> Signed <input type="checkbox"/> Attached

County/City Local CHDP Program: \_\_\_\_\_

Requested by: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Print Name of Deputy Director

Signature: \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_  
Signature of Deputy Director

SYSTEM ADMINISTRATOR (SA) USE ONLY		
Application	Date Completed	SA Initial
Establish CHDP		
Establish CHDP		

**Questions?** Contact Brenda Washington: [bwashin2@dhs.ca.gov](mailto:bwashin2@dhs.ca.gov)  
 Phone: (916) 327-2271  
 Fax: (916) 440-5300 or (916) 327-0997

**Children's Medical Services Branch  
DEPARTMENT OF HEALTH SERVICES  
Child Health & Disability Prevention (CHDP) Program  
Confidentiality Form Release  
COMPUTER FILES RELEASE/ACCESS  
OF THE MEDI-CAL and CHDP PROGRAM**

**CONFIDENTIALITY OATH**

As a condition of obtaining access to data and fiscal/reporting records utilized/maintained by the State Department of Health Services and its fiscal intermediary, I agree not to:

1. Divulge any information obtained in the course of my assigned duties to unauthorized persons, and
2. Publish or otherwise make public any information regarding persons(s) receiving Medi-Cal and CHDP services such that the persons who received such services are identifiable.

Access to such data shall be limited to state and federal personnel who require the information in the performance of their duties, and to others such as local health department CHDP program staff as may be authorized by the Department of Health Services.

I recognize that unauthorized release of confidential information may be subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

County/City Local CHDP Program \_\_\_\_\_.

Signature(s) CHDP Data Users:

Date:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Return Form to: Department of Health Services  
Children's Medical Services – Attn: Brenda Washington  
1515 K Street, Room 400  
Sacramento, CA 95814**